ARC 8899B

HUMAN SERVICES DEPARTMENT[441]

Adopted and Filed Emergency

Pursuant to the authority of Iowa Code section 249A.4 and 2010 Iowa Acts, House File 2526, section 33(13), the Department of Human Services amends Chapter 79, "Other Policies Relating to Providers of Medical and Remedial Care," and Chapter 85, "Services in Psychiatric Institutions," Iowa Administrative Code.

These amendments continue the rate reductions instituted in December 2009 pursuant to Executive Order 19 for state fiscal year 2011. Rule 441—79.16(249A), which implemented the temporary reimbursement decreases, is rescinded. The reimbursement rules for particular providers are amended to make the same reductions. Reimbursement rules for psychiatric medical institutions for children (PMICs) are revised to continue the interim payment system for another year.

Hospital reimbursement rules are revised to:

• Correct dates and status indicators related to the diagnosis-related group (DRG) and ambulatory payment classification (APC) reimbursement methodologies for inpatient services and outpatient services, respectively.

• Eliminate enhanced disproportionate share hospital (DSH) payments and enhanced graduate medical education (GME) payments.

• Replace the enhanced payments with the Iowa non-state-government-owned acute care teaching hospital DSH payments.

• Establish an Iowa state-owned teaching hospital disproportionate share fund from which payments shall be made monthly to qualifying hospitals.

The requirement that payments to public hospitals and nursing facilities not exceed their actual costs is eliminated as unnecessary in light of the repeal of the state statutory provision limiting payments to public hospitals and nursing facilities to their costs (2010 Iowa Acts, Senate File 2156, section 16).

Some language has been revised to clarify current policy. Obsolete dates are updated. References to the mental retardation waiver are updated to "intellectual disabilities waiver."

These amendments do not provide for waivers in specified situations. Requests for the waiver of any rule may be submitted under the Department's general rule on exceptions at 441—1.8(17A,217).

The Council on Human Services adopted these amendments June 9, 2010.

In compliance with Iowa Code section 17A.4(3), the Department finds that notice and public participation are unnecessary because these amendments implement 2010 Iowa Acts, House File 2526, section 33, which authorizes the Department to adopt rules without notice and public participation.

The Department also finds, pursuant to Iowa Code section 17A.5(2)"b"(1), that the normal effective date of these amendments should be waived, as authorized by 2010 Iowa Acts, House File 2526, section 33.

These amendments are also published herein under Notice of Intended Action as **ARC 8900B** to allow for public comment.

These amendments are intended to implement Iowa Code section 249A.4 and 2010 Iowa Acts, House File 2526, section 33, and 2010 Iowa Acts, Senate File 2156, section 16.

These amendments shall become effective July 1, 2010.

The following amendments are adopted.

ITEM 1. Amend rule 441—79.1(249A), introductory paragraph, as follows:

441—79.1(249A) Principles governing reimbursement of providers of medical and health services. The basis of payment for services rendered by providers of services participating in the medical assistance program is either a system based on the provider's allowable costs of operation or a fee schedule. Generally, institutional types of providers such as hospitals and nursing facilities are reimbursed on a cost-related basis, and practitioners such as physicians, dentists, optometrists, and similar providers are reimbursed on the basis of a fee schedule. ~~Payments to health care providers that~~

~~are owned or operated by Iowa state or non-state government entities shall not exceed the provider's cost of providing services to Medicaid members.~~ Providers of service must accept reimbursement based upon the department's methodology without making any additional charge to the member.

ITEM 2. Amend paragraph **79.1(1)"e"** as follows:

e. Retrospectively limited prospective rates. Providers are reimbursed on the basis of a rate for a unit of service calculated prospectively for each participating provider (and, for supported community living daily rates, for each consumer or site) based on projected or historical costs of operation~~,~~ subject to the maximums listed in subrule 79.1(2) and to retrospective adjustment ~~based on actual, current costs of operation so as not to exceed reasonable and proper costs by more than 2.5 percent~~ pursuant to subparagraph 79.1(1)*"e"*(3).

(1) The prospective rates for new providers who have not submitted six months of cost reports will be based on a projection of the provider's reasonable and proper costs of operation until the provider has submitted an annual cost report that includes a minimum of six months of actual costs.

(2) The prospective rates paid established providers who have submitted an annual report with a minimum of a six-month history are based on reasonable and proper costs in a base period and are adjusted annually for inflation.

(3) The prospective rates paid to both new and established providers are subject to ~~the maximums listed in subrule 79.1(2) and to~~ retrospective adjustment based on the provider's actual, current costs of operation as shown by financial and statistical reports submitted by the provider, so as not to exceed reasonable and proper costs actually incurred ~~by more than 2.5 percent~~.

ITEM 3. Amend subrule 79.1(2) as follows:

79.1(2) *Basis of reimbursement of specific provider categories.*

Provider category	Basis of reimbursement	Upper limit
Advanced registered nurse practitioners	Fee schedule	Fee schedule in effect ~~6/30/08 plus 1%.~~ 11/30/09 less 5%.
Ambulance	Fee schedule	Ground ambulance: Fee schedule in effect ~~6/30/08 plus 1%.~~ 11/30/09 less 5%. Air ambulance: Fee schedule in effect ~~6/30/08 plus 1%.~~ 11/30/09 less 5%.
Ambulatory surgical centers	~~Fee~~ Base rate fee schedule as determined by Medicare. See 79.1(3)	Fee schedule in effect ~~6/30/08 plus 1%.~~ 11/30/09 less 5%.
Area education agencies	Fee schedule	Fee schedule in effect 6/30/00 plus 0.7%.
Audiologists	Fee schedule	Fee schedule in effect ~~6/30/08 plus 1%.~~ 11/30/09 less 5%.
Behavioral health services	Fee schedule	Fee schedule in effect 11/30/09 less 5%.
Birth centers	Fee schedule	Fee schedule in effect ~~6/30/08 plus 1%.~~ 11/30/09 less 5%.
Chiropractors	Fee schedule	Fee schedule in effect ~~6/30/08 plus 1%.~~ 11/30/09 less 5%.
Clinics	Fee schedule	Maximum physician reimbursement rate.
Community mental health centers and providers of mental health services to county residents pursuant to a waiver approved under Iowa Code section 225C.7(3)	Retrospective cost-related. See 79.1(25)	100% of reasonable Medicaid cost as determined by Medicare cost reimbursement principles.

Provider category	Basis of reimbursement	Upper limit
Dentists	Fee schedule	Fee schedule in effect ~~6/30/08 plus 1%.~~ 11/30/09 less 2.5%.
Durable medical equipment, prosthetic devices and medical supply dealers	Fee schedule. See 79.1(4)	Fee schedule in effect ~~6/30/08 plus 1%.~~ 11/30/09 less 5%.
Family planning clinics	Fee schedule	~~Beginning 2/1/10, fee~~ Fee schedule in effect ~~6/30/09 plus 5%~~ 1/31/10.
Federally qualified health centers	Retrospective cost-related. See 441—88.14(249A)	1. Prospective payment rate as required by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA 2000) or an alternative methodology allowed thereunder, as specified in "2" below. 2. 100% of reasonable cost as determined by Medicare cost reimbursement principles. 3. In the case of services provided pursuant to a contract between an FQHC and a managed care organization (MCO), reimbursement from the MCO shall be supplemented to achieve "1" or "2" above.
HCBS waiver service providers, including:		Except as noted, limits apply to all waivers that cover the named provider.
1. Adult day care	Fee schedule	For AIDS/HIV, brain injury, elderly, and ill and handicapped waivers: Veterans Administration contract rate or ~~$22.12~~ $21.57 per half-day, ~~$44.03~~ $42.93 per full day, or ~~$66.03~~ $64.38 per extended day if no Veterans Administration contract. For ~~mental retardation~~ intellectual disabilities waiver: County contract rate or, in the absence of a contract rate, ~~$29.47~~ $28.73 per half-day, ~~$58.83~~ $57.36 per full day, or ~~$75.00~~ $73.13 per extended day.
2. Emergency response system	Fee schedule	Initial one-time fee ~~$49.53~~ $48.29. Ongoing monthly fee ~~$38.52~~ $37.56.

Provider category	Basis of reimbursement	Upper limit
3. Home health aides	Retrospective cost-related	For AIDS/HIV, elderly, and ill and handicapped waivers: Lesser of maximum Medicare rate in effect ~~6/30/08 plus 1%~~ 11/30/09 or maximum Medicaid rate in effect ~~6/30/08 plus 1%.~~ 11/30/09 less 5%. For ~~mental retardation~~ intellectual disabilities waiver: Lesser of maximum Medicare rate in effect ~~6/30/08 plus 1%~~ 11/30/09 or maximum Medicaid rate in effect ~~6/30/08 plus 1%~~ 11/30/09 less 5%, converted to an hourly rate.
4. Homemakers	Fee schedule	Maximum of ~~$19.81~~ $19.31 per hour.
5. Nursing care	For elderly and ~~mental retardation~~ intellectual disabilities waivers: Fee schedule as determined by Medicare.	For elderly waiver: ~~$82.92~~ $80.85 per visit. For ~~mental retardation~~ intellectual disabilities waiver: Lesser of maximum Medicare rate in effect ~~6/30/08 plus 1%~~ 11/30/09 or maximum Medicaid rate in effect ~~6/30/08 plus 1%~~ 11/30/09 less 5%, converted to an hourly rate.
	For AIDS/HIV and ill and handicapped waivers: Agency's financial and statistical cost report and Medicare percentage rate per visit.	For AIDS/HIV and ill and handicapped waivers: Cannot exceed ~~$82.92~~ $80.85 per visit.
6. Respite care when provided by:		
Home health agency:		
Specialized respite	Cost-based rate for nursing services provided by a home health agency	Lesser of maximum Medicare rate in effect ~~6/30/08 plus 1%~~ 11/30/09 or maximum Medicaid rate in effect ~~6/30/08 plus 1%~~ 11/30/09 less 2.5%, converted to an hourly rate, not to exceed $296.94 per day.
Basic individual respite	Cost-based rate for home health aide services provided by a home health agency	Lesser of maximum Medicare rate in effect ~~6/30/08 plus 1%~~ 11/30/09 or maximum Medicaid rate in effect ~~6/30/08 plus 1%~~ 11/30/09 less 2.5%, converted to an hourly rate, not to exceed $296.94 per day.
Group respite	Retrospectively limited prospective rates. See 79.1(15)	~~$13.12~~ $12.79 per hour not to exceed $296.94 per day.
Home care agency:		
Specialized respite	Retrospectively limited prospective rates. See 79.1(15)	~~$33.75~~ $32.91 per hour not to exceed $296.94 per day.
Basic individual respite	Retrospectively limited prospective rates. See 79.1(15)	~~$18.01~~ $17.56 per hour not to exceed $296.94 per day.
Group respite	Retrospectively limited prospective rates. See 79.1(15)	~~$13.12~~ $12.79 per hour not to exceed $296.94 per day.

Provider category	Basis of reimbursement	Upper limit
Nonfacility care:		
Specialized respite	Retrospectively limited prospective rates. See 79.1(15)	~~$33.75~~ $32.91 per hour not to exceed $296.94 per day.
Basic individual respite	Retrospectively limited prospective rates. See 79.1(15)	~~18.01~~ $17.56 per hour not to exceed $296.94 per day.
Group respite	Retrospectively limited prospective rates. See 79.1(15)	~~$13.12~~ $12.79 per hour not to exceed $296.94 per day.
Facility care:		
Hospital or nursing facility providing skilled care	Fee schedule	~~$13.12~~ $12.79 per hour not to exceed daily per diem for skilled nursing facility level of care.
Nursing facility	Fee schedule	~~$13.12~~ $12.79 per hour not to exceed daily per diem for nursing facility level of care.
Camps	Retrospectively limited prospective rates. See 79.1(15)	~~$13.12~~ $12.79 per hour not to exceed $296.94 per day.
Adult day care	Fee schedule	~~$13.12~~ $12.79 per hour not to exceed rate for regular adult day care services.
Intermediate care facility for the mentally retarded	Fee schedule	~~$13.12~~ $12.79 per hour not to exceed daily per diem for ICF/MR level of care.
Residential care facilities for persons with mental retardation	Fee schedule	~~$13.12~~ $12.79 per hour not to exceed contractual daily per diem.
Foster group care	Fee schedule	~~$13.12~~ $12.79 per hour not to exceed daily per diem rate for child welfare services.
Child care facilities	Fee schedule	~~$13.12~~ $12.79 per hour not to exceed contractual daily per diem.
7. Chore service	Fee schedule	~~$7.71~~ $7.52 per half hour.
8. Home-delivered meals	Fee schedule	~~$7.71~~ $7.52 per meal. Maximum of 14 meals per week.
9. Home and vehicle modification	Fee schedule	For elderly waiver: $1,010 lifetime maximum. For ~~mental retardation~~ intellectual disabilities waiver: $5,050 lifetime maximum. For brain injury, ill and handicapped and physical disability waivers: $6,060 per year.
10. Mental health outreach providers	Fee schedule	On-site Medicaid reimbursement rate for center or provider. Maximum of 1440 units per year.
11. Transportation	Fee schedule	County contract rate or, in the absence of a contract rate, the rate set by the area agency on aging.

Provider category	Basis of reimbursement	Upper limit
12. Nutritional counseling	Fee schedule	~~$8.25~~ $8.04 per unit.
13. Assistive devices	Fee schedule	~~$110.05~~ $107.30 per unit.
14. Senior companion	Fee schedule	~~$6.59~~ $6.44 per hour.
15. Consumer-directed attendant care provided by:		
Agency (other than an elderly waiver assisted living program)	Fee agreed upon by consumer and provider	~~$20.20~~ $19.70 per hour not to exceed the daily rate of ~~$116.72~~ $113.80 per day.
Assisted living program (for elderly waiver only)	Fee agreed upon by consumer and provider	For elderly waiver only: ~~$1,117~~ $1,089.08 per calendar month. Rate must be prorated per day for a partial month, at a rate not to exceed ~~$36.71~~ $35.79 per day.
Individual	Fee agreed upon by consumer and provider	~~$13.47~~ $13.13 per hour not to exceed the daily rate of ~~$78.56~~ $76.60 per day.
16. Counseling		
Individual:	Fee schedule	~~$10.79~~ $10.52 per unit.
Group:	Fee schedule	~~$43.14~~ $42.06 per hour.
17. Case management	Fee schedule with cost settlement. See 79.1(1)*"d."*	For brain injury waiver: Retrospective cost-settled rate. For elderly waiver: Quarterly revision of reimbursement rate as necessary to maintain projected expenditures within the amounts budgeted under the appropriations made for the medical assistance program for the fiscal year.
18. Supported community living	Retrospectively limited prospective rates. See 79.1(15)	~~$34.98~~ $34.11 per hour, ~~$78.88~~ $76.91 per day not to exceed the maximum daily ICF/MR per diem less 2.5%.
19. Supported employment:		
Activities to obtain a job:		
Job development	Fee schedule	~~$909~~ $886.28 per unit (job placement). Maximum of two units per 12 months.
Employer development	Fee schedule	~~$909~~ $886.28 per unit (job placement). Maximum of two units per 12 months.
Enhanced job search	Retrospectively limited prospective rates. See 79.1(15)	Maximum of ~~$34.98~~ $34.11 per hour and 26 hours per 12 months.

Provider category	Basis of reimbursement	Upper limit
Supports to maintain employment	Retrospectively limited prospective rates. See 79.1(15)	Maximum of ~~$34.98~~ $34.11 per hour for all activities other than personal care and services in an enclave setting. Maximum of ~~$19.81~~ $19.31 per hour for personal care. Maximum of ~~$6.19~~ $6.04 per hour for services in an enclave setting. Total not to exceed ~~$2,883.71~~ $2,811.62 per month. Maximum of 40 units per week.
20. Specialized medical equipment	Fee schedule	$6,060 per year.
21. Behavioral programming	Fee schedule	~~$10.79~~ $10.52 per 15 minutes.
22. Family counseling and training	Fee schedule	~~$43.14~~ $42.06 per hour.
23. Prevocational services	Fee schedule	For the brain injury waiver: ~~$37.44~~ $36.50 per day. For the ~~mental retardation~~ intellectual disabilities waiver: County contract rate or, in absence of a contract rate, ~~$48.22~~ $47.01 per day.
24. Interim medical monitoring and treatment:		
Home health agency (provided by home health aide)	Cost-based rate for home health aide services provided by a home health agency	Lesser of maximum Medicare rate in effect ~~6/30/08 plus 1%~~ 11/30/09 or maximum Medicaid rate in effect ~~6/30/08 plus 1%~~ 11/30/09 less 5%, converted to an hourly rate.
Home health agency (provided by nurse)	Cost-based rate for nursing services provided by a home health agency	Lesser of maximum Medicare rate in effect ~~6/30/08 plus 1%~~ 11/30/09 or maximum Medicaid rate in effect ~~6/30/08 plus 1%,~~ 11/30/09 less 5%, converted to an hourly rate.
Child development home or center	Fee schedule	~~$13.12~~ $12.79 per hour.
25. Residential-based supported community living	Retrospectively limited prospective rates. See 79.1(15)	The maximum daily per diem for ICF/MR less 2.5%.
26. Day habilitation	Fee schedule	County contract rate or, in the absence of a contract rate, ~~$13.21~~ $12.88 per hour, ~~$32.15~~ $31.35 per half-day, or ~~$64.29~~ $62.68 per day.
27. Environmental modifications and adaptive devices	Fee schedule	$6,060 per year.
28. Family and community support services	Retrospectively limited prospective rates. See 79.1(15)	~~$34.98~~ $34.11 per hour.
29. In-home family therapy	Fee schedule	~~$93.63~~ $91.29 per hour.
30. Financial management services	Fee schedule	~~$65.65~~ $64.01 per enrolled ~~consumer~~ member per month.
31. Independent support broker	Rate negotiated by ~~consumer~~ member	~~$15.15~~ $14.77 per hour.

Provider category	Basis of reimbursement	Upper limit
32. Self-directed personal care	Rate negotiated by ~~consumer~~ member	Determined by ~~consumer's~~ member's individual budget.
33. Self-directed community supports and employment	Rate negotiated by ~~consumer~~ member	Determined by ~~consumer's~~ member's individual budget.
34. Individual-directed goods and services	Rate negotiated by ~~consumer~~ member	Determined by ~~consumer's~~ member's individual budget.
Hearing aid dispensers	Fee schedule plus product acquisition cost	Fee schedule in effect ~~6/30/08 plus 1%~~ 11/30/09 less 5%.
Home- and community-based habilitation services:		
1. Case management	Fee schedule with cost settlement. See 79.1(1)*"d."*	Retrospective cost-settled rate.
2. Home-based habilitation	Retrospective cost-related. See 79.1(24)	$46.70 per hour or $105.97 per day.
3. Day habilitation	Retrospective cost-related. See 79.1(24)	$13.21 per hour, $32.15 per half-day, or $64.29 per day.
4. Prevocational habilitation	Retrospective cost-related. See 79.1(24)	$9.91 per hour, $24.11 per half-day, or $48.22 per day.
5. Supported employment:		
Activities to obtain a job:		
Job development	Fee schedule	$909 per unit (job placement). Maximum of two units per 12 months.
Employer development	Fee schedule	$909 per unit (job placement). Maximum of two units per 12 months.
Enhanced job search	Retrospective cost-related. See 79.1(24)	Maximum of $34.98 per hour and 26 hours per 12 months.
Supports to maintain employment	Retrospective cost-related. See 79.1(24)	$6.19 per hour for services in an enclave setting; $19.81 per hour for personal care; and $34.98 per hour for all other services. Total not to exceed $2,883.71 per month. Maximum of 40 units per week.
Home health agencies		
1. Skilled nursing, physical therapy, occupational therapy, home health aide, and medical social services; home health care for maternity patients and children	Retrospective cost-related	Lesser of maximum Medicare rate in effect ~~6/30/08 plus 1%~~ 11/30/09 or maximum Medicaid rate in effect ~~6/30/08 plus 1%.~~ 11/30/09 less 5%.
2. Private duty nursing and personal care for persons aged 20 or under	Interim fee schedule with retrospective cost settlement	Medicaid rate in effect ~~6/30/08 plus 1%.~~ 11/30/09 less 5%.
3. Administration of vaccines	Physician fee schedule	Physician fee schedule rate.
Hospices	Fee schedule as determined by Medicare	Medicare cap. (See 79.1(14)*"d"*)

Provider category	Basis of reimbursement	Upper limit
Hospitals (Critical access)	Retrospectively adjusted prospective rates. See 79.1(1)*"g"* and 79.1(5)	The reasonable cost of covered services provided to medical assistance recipients or the upper limits for other hospitals, whichever is greater.
Hospitals (Inpatient)	Prospective reimbursement. See 79.1(5)	Reimbursement rate in effect ~~6/30/08 plus 1%.~~ 11/30/09 less 5%.
Hospitals (Outpatient)	Prospective reimbursement or hospital outpatient fee schedule. See 79.1(16)*"c"*	Ambulatory payment classification rate or hospital outpatient fee schedule rate in effect ~~7/01/08~~ 11/30/09 less 5%.
Independent laboratories	Fee schedule. See 79.1(6)	Medicare fee schedule less 5%. See 79.1(6)
Indian health service 638 facilities	1. Base rate as determined by the United States Office of Management and Budget for outpatient visits for American Indian and Alaskan native members.	1. Office of Management and Budget rate published in the Federal Register for outpatient visit rate.
	2. Fee schedule for service provided for all other Medicaid members.	2. Fee schedule.
Infant and toddler program providers	Fee schedule	Fee schedule.
Intermediate care facilities for the mentally retarded	Prospective reimbursement. See 441—82.5(249A)	Eightieth percentile of facility costs as calculated from annual cost reports.
Lead inspection agency	Fee schedule	Fee schedule in effect ~~6/30/08 plus 1%.~~ 11/30/09 less 5%.
Local education agency services providers	Fee schedule	Fee schedule.
Maternal health centers	Reasonable cost per procedure on a prospective basis as determined by the department based on financial and statistical data submitted annually by the provider group	Fee schedule in effect ~~6/30/08 plus 1%.~~ 11/30/09 less 5%.
Nursing facilities: 1. Nursing facility care	Prospective reimbursement. See 441—subrule 81.10(1) and 441—81.6(249A). The percentage of the median used to calculate the direct care excess payment allowance ceiling under 441—81.6(16)*"d"*(1)"1" and (2)"1" is 95% of the patient-day-weighted median. The percentage of the difference used to calculate the direct care excess payment allowance is 0%. The percentage of the median used to calculate the direct care excess payment allowance limit is 10% of the patient-day-weighted median. The percentage of	See 441—subrules 81.6(4) and 81.6(14) and paragraph 81.6(16)*"f."* The direct care rate component limit under 441—81.6(16)*"f"*(1) and (2) is 120% of the patient-day-weighted median. The non-direct care rate component limit under 441—81.6(16)*"f"* (1) and (2) is 110% of the patient-day-weighted median.

Provider category	Basis of reimbursement	Upper limit
	the median used to calculate the non-direct care excess payment allowance ceiling under 441—81.6(16)*"d"*(1)"2" and (2)"2" is 96% of the patient-day-weighted median. The percentage of the difference used to calculate the non-direct care excess payment allowance limit is 0%. The percentage of the median used to calculate the non-direct care excess payment allowance limit is 8% of the patient-day-weighted median.	
2. Hospital-based, Medicare-certified nursing care	Prospective reimbursement. See 441—subrule 81.10(1) and 441—81.6(249A). The percentage of the median used to calculate the direct care excess payment allowance ceiling under 441—81.6(16)*"d"*(3)"1" is 95% of the patient-day-weighted median. The percentage of the difference used to calculate the direct care excess payment allowance is 0%. The percentage of the median used to calculate the direct care excess payment allowance limit is 10% of the patient-day-weighted median. The percentage of the median used to calculate the non-direct care excess payment allowance ceiling under 441—81.6(16)*"d"*(3)"2" is 96% of the patient-day-weighted median. The percentage of the difference used to calculate the non-direct care excess payment allowance limit is 0%. The percentage of the median used to calculate the non-direct care excess payment allowance limit is 8% of the patient-day-weighted median.	See 441—subrules 81.6(4) and 81.6(14) and paragraph 81.6(16)*"f."* The direct care rate component limit under 441—81.6(16)*"f"*(3) is 120% of the patient-day-weighted median. The non-direct care rate component limit under 441—81.6(16)*"f"*(3) is 110% of the patient-day-weighted median.
Occupational therapists	Fee schedule	~~Medicare fee schedule.~~ Fee schedule in effect 11/30/09 less 5%.
Opticians	Fee schedule. Fixed fee for lenses and frames; other optical materials at product acquisition cost	Fee schedule in effect ~~6/30/08 plus 1%.~~ 11/30/09 less 5%.
Optometrists	Fee schedule. Fixed fee for lenses and frames; other optical materials at product acquisition cost	Fee schedule in effect ~~6/30/08 plus 1%.~~ 11/30/09 less 5%.
Orthopedic shoe dealers	Fee schedule	Fee schedule in effect ~~6/30/08 plus 1%.~~ 11/30/09 less 5%.

Provider category	Basis of reimbursement	Upper limit
Pharmaceutical case management	Fee schedule. See 79.1(18)	Refer to 79.1(18).
Physical therapists	Fee schedule	Fee schedule in effect ~~6/30/08 plus 1%.~~ 11/30/09 less 5%.
Physicians (doctors of medicine or osteopathy)	Fee schedule. See 79.1(7)*"a"*	Fee schedule in effect ~~6/30/08 plus 1%.~~ 11/30/09 less 5%.
Anesthesia services	Fee schedule	Fee schedule in effect ~~6/30/08 plus 1%.~~ 11/30/09 less 5%.
Podiatrists	Fee schedule	Fee schedule in effect ~~6/30/08 plus 1%.~~ 11/30/09 less 5%.
Prescribed drugs	See 79.1(8)	~~$4.57~~ $4.34 dispensing fee. (See 79.1(8)*"a," "b,"* and *"e."*)
Psychiatric medical institutions for children 1. Inpatient	Retrospective cost-related	~~Effective July 1, 2009, actual~~ Actual and allowable cost not to exceed a maximum for non-state-owned providers of 103% of patient-day-weighted average costs of non-state-owned providers located within Iowa less 5%.
2. Outpatient day treatment	Fee schedule	Fee schedule in effect ~~6/30/08 plus 1%.~~ 11/30/09 less 5%.
Psychologists	Fee schedule	Fee schedule in effect ~~6/30/08 plus 1%.~~ 11/30/09 less 5%.
Rehabilitation agencies	Fee schedule	Medicare fee schedule less 5%; refer to 79.1(21).
Remedial services	Retrospective cost-related plus 1%. See 79.1(23)	110% of average cost less 5%.
Rural health clinics	Retrospective cost-related. See 441—88.14(249A)	1. Prospective payment rate as required by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA 2000) or an alternative methodology allowed thereunder, as specified in "2" below. 2. 100% of reasonable cost as determined by Medicare cost reimbursement principles. 3. In the case of services provided pursuant to a contract between an RHC and a managed care organization (MCO), reimbursement from the MCO shall be supplemented to achieve "1" or "2" above.
Screening centers	Fee schedule	Reimbursement rate for center in effect ~~6/30/08 plus 1%.~~ 11/30/09 less 5%.
State-operated institutions	Retrospective cost-related	
Targeted case management providers	Fee for service with cost settlement. See 79.1(1)*"d."*	Retrospective cost-settled rate.

ITEM 4. Amend paragraph **79.1(5)"a,"** definitions of "Base year cost report" and "Graduate medical education and disproportionate share fund," as follows:

"Base year cost report," ~~for rates effective October 1, 2005, shall mean~~ means the hospital's cost report with fiscal year end on or after January 1, ~~2004~~ 2007, and before January 1, ~~2005~~ 2008, except as noted in 79.1(5)*"x."* Cost reports shall be reviewed using Medicare's cost reporting and cost reimbursement principles for those cost reporting periods.

"Graduate medical education and disproportionate share fund" or *"GME/DSH fund"* ~~shall mean~~ means a reimbursement fund developed as an adjunct reimbursement methodology to directly reimburse qualifying hospitals for the direct and indirect costs associated with the operation of graduate medical education programs and the costs associated with the treatment of a disproportionate share of poor, indigent, nonreimbursed or nominally reimbursed patients for inpatient services.

ITEM 5. Adopt the following **new** definitions in paragraph **79.1(5)"a"**:

"GME/DSH fund apportionment claim set" means the hospital's applicable Medicaid claims paid from July 1, 2008, through June 30, 2009. The claim set is updated in July of every third year.

"GME/DSH fund implementation year" means 2009.

"Medicaid claim set" means the hospital's applicable Medicaid claims for the period of January 1, 2006, through December 31, 2007, and paid through March 31, 2008.

"Rebasing implementation year" means 2008 and every three years thereafter.

ITEM 6. Amend paragraph **79.1(5)"c"** as follows:

c. Calculation of Iowa-specific weights and case-mix index. ~~Using all applicable claims for the period January 1, 2003, through December 31, 2004, and paid through March 31, 2005,~~ From the Medicaid claim set, the recalibration for rates effective October 1, ~~2005~~ 2008, will use all normal inlier claims, discard short stay outliers, discard transfers where the final payment is less than the full DRG payment, include transfers where the full payment is greater than or equal to the full DRG payment, and use only the estimated charge for the inlier portion of long stay outliers and cost outliers for weighting calculations. These are referred to as trimmed claims.

(1) Iowa-specific weights are calculated ~~from~~ with Medicaid charge data ~~on discharge dates occurring from January 1, 2003, to December 31, 2004, and paid through March 31, 2005~~ from the Medicaid claim set using trimmed claims. Medicaid charge data for hospitals receiving reimbursement as critical access hospitals during any of the period included in the base-year cost report shall not be used in calculating Iowa-specific weights. One weight is determined for each DRG with noted exceptions. Weights are determined through the following calculations:

1. to 5. No change.

(2) The hospital-specific case-mix index is computed by taking each hospital's trimmed claims that match the hospital's ~~2004 fiscal year and paid through March 31, 2005~~ base year cost reporting period, summing the assigned DRG weights associated with those claims and dividing by the total number of Medicaid claims associated with that specific hospital for that period. Case-mix indices are not computed for hospitals receiving reimbursement as critical access hospitals.

(3) For purposes of calculating the disproportionate share rate only, a separate hospital-specific case-mix index shall be computed for any hospital that qualifies for a disproportionate share payment only as a children's hospital~~, using~~. The computation shall use only claims and associated DRG weights ~~only~~ for services provided to patients under 18 years of age at the time of admission in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age.

ITEM 7. Amend subparagraph **79.1(5)"k"(2)** as follows:

(2) Base amounts shall be rebased and weights recalibrated in 2005 and every three years thereafter. Cost reports used in rebasing shall be the hospital fiscal year-end Form CMS 2552, Hospital and Healthcare Complex Cost Report, as submitted to Medicare in accordance with Medicare cost report submission time lines for the hospital fiscal year ending during the ~~preceding~~ calendar year preceding the rebasing implementation year. If a hospital does not provide this cost report to the Iowa Medicaid enterprise provider cost audits and rate-setting unit by May 31 of a ~~year in which~~ rebasing

~~occurs~~ implementation year, the most recent submitted cost report will be used with the addition of a hospital market basket index inflation factor.

ITEM 8. Amend paragraph **79.1(5)"t"** as follows:

t. Limitations and application of limitations on payment. Diagnosis-related group payments are subject to the upper payment limits as stated in 42 CFR 447.271 and 42 CFR 447.272 as amended to September 5, 2001.

~~Payment limits as stated in subparagraphs (1) and (2) below are applied in the aggregate during the cost settlement process at the completion of the hospital's fiscal year end. The payment limit stated in subparagraph (3) is applied to aggregate Medicaid payments at the end of the state's fiscal year.~~

(1) The department may not pay a provider more for inpatient hospital services under Medicaid than the provider's customary charges to the general public for the services. This limit is applied in the aggregate during the cost settlement process at the end of the hospital's fiscal year.

~~(2) Payments to a hospital that is owned or operated by state or non-state government shall not exceed the hospital's actual medical assistance program costs. The department shall perform a cost settlement annually after the desk review or audit of the hospital's cost report. The department shall determine the aggregate payments made to the hospital under the diagnosis-related group methodology and compare this amount to the hospital's actual medical assistance program costs as determined from the audit or desk review of the hospital's cost report. For purposes of this determination, payments shall include amounts received from the Medicaid program, including graduate medical education payments and outlier payments, as well as patient and third-party payments up to the Medicaid-allowed amount. If the payments exceed the hospital's actual medical assistance program costs, the amount by which payments exceed actual costs shall be requested and collected from the hospital.~~

~~(3)~~ (2) Aggregate payments to hospitals and state-operated hospitals may not exceed the amount that can reasonably be estimated would have been paid for those services under Medicare payment principles. This limit is applied to aggregate Medicaid payments at the end of the state's fiscal year.

ITEM 9. Adopt the following **new** paragraphs **79.1(5)"u"** and **"v"**:

u. State-owned teaching hospital disproportionate share payment. In addition to payments from the graduate medical education and disproportionate share fund made pursuant to paragraph 79.1(5)*"y,"* payment shall be made to Iowa hospitals qualifying for the Iowa state-owned teaching hospital disproportionate share fund. Interim monthly payments based on estimated allowable costs will be paid to qualifying hospitals under this paragraph.

(1) Qualifying criteria. A hospital qualifies for Iowa state-owned teaching hospital disproportionate share payments if it qualifies for disproportionate share payments pursuant to paragraph 79.1(5)*"y"* and is an Iowa state-owned hospital with more than 500 beds and eight or more distinct residency specialty or subspecialty programs recognized by the American College of Graduate Medical Education.

(2) Allocation to fund. The total amount of funding that is allocated on July 1 of each year to the Iowa state-owned teaching hospital disproportionate share fund is $26,633,430.

(3) Amount of payment. The total amount of disproportionate share payments from the graduate medical education and disproportionate share fund and from the Iowa state-owned teaching hospital disproportionate share fund shall not exceed the amount of the state's allotment under Public Law 102-234. In addition, the total amount of all disproportionate share payments shall not exceed the hospital-specific disproportionate share limits under Public Law 103-666.

(4) Final disproportionate share adjustment. The department's total year-end disproportionate share obligations to a qualifying hospital will be calculated following completion of the desk review or audit of CMS 2552-96, Hospital and Healthcare Complex Cost Report.

v. Non-state-owned teaching hospital disproportionate share payment. In addition to payments from the graduate medical education and disproportionate share fund made pursuant to paragraph 79.1(5)*"y,"* payment shall be made to Iowa hospitals qualifying for Iowa non-state-government-owned acute care teaching hospital disproportionate share payments. Interim monthly payments based on estimated allowable costs will be paid to qualifying hospitals under this paragraph.

(1) Qualifying criteria. A hospital qualifies for the Iowa non-state-government-owned acute care teaching hospital disproportionate share payments if it qualifies for disproportionate share payments pursuant to paragraph 79.1(5)*"y"* and is an Iowa non-state-government-owned acute care teaching hospital located in a county with a population over 350,000.

(2) Amount of payment. The total amount of disproportionate share payments pursuant to paragraph 79.1(5)*"y"* and the Iowa non-state-government-owned acute care teaching hospital disproportionate share payments shall not exceed the amount of the state's allotment under Public Law 102-234. In addition, the total amount of all disproportionate share payments shall not exceed the hospital-specific disproportionate share limits under Public Law 103-666.

(3) Final disproportionate share adjustment. The department's total year-end disproportionate share obligations to a qualifying hospital will be calculated following completion of the desk review or audit of CMS 2552-96, Hospital and Healthcare Complex Cost Report. The department's total year-end disproportionate share obligation shall not exceed the difference between $51 million and the actual IowaCare expansion population claims submitted and paid by the Iowa Medicaid enterprise.

ITEM 10. Amend subparagraphs **79.1(5)"y"(2)** and **(3)** and **79.1(5)"y"(5)** to **(9)** as follows:

(2) Allocation to fund for direct medical education. ~~Except as reduced pursuant to subparagraph 79.1(5)*"y"*(3), the~~ The total state fiscal year annual amount of funding that is allocated to the graduate medical education and disproportionate share fund for direct medical education related to inpatient services ~~for July 1, 2008, through June 30, 2009,~~ is ~~$8,642,112~~ $8,210,006. If a hospital fails to qualify for direct medical education payments from the fund because the hospital does not report direct medical education costs that qualify for payment as medical education costs under the Medicare program in the most recent cost report submitted before the start of the state fiscal year for which payments are being made, the amount of money that would have been paid to that hospital shall be removed from the fund.

(3) Distribution to qualifying hospitals for direct medical education. Distribution of the amount in the fund for direct medical education shall be on a monthly basis. To determine the amount to be distributed to each qualifying hospital for direct medical education, the following formula is used:

1. Multiply the total of all DRG weights for claims paid from ~~July 1, 2005, through June 30, 2006,~~ the GME/DSH fund apportionment claim set for each hospital reporting direct medical education costs that qualify for payment as medical education costs under the Medicare program in the hospital's base year cost report by each hospital's direct medical education rate to obtain a dollar value.

2. Sum the dollar values for each hospital, then divide each hospital's dollar value by the total dollar value, resulting in a percentage.

3. Multiply each hospital's percentage by the amount allocated for direct medical education to determine the payment to each hospital.

~~Effective for payments from the fund for July 2006, the state fiscal year used as the source of DRG weights shall be updated to July 1, 2005, through June 30, 2006. Thereafter, the state fiscal year used as the source of DRG weights shall be updated by a three-year period effective for payments from the fund for July of every third year.~~

~~If a hospital fails to qualify for direct medical education payments from the fund because it does not report direct medical education costs that qualify for payment as medical education costs under the Medicare program in the most recent cost report submitted before the start of the state fiscal year for which payments are being made, the amount of money that would have been paid to that hospital shall be removed from the fund.~~

(5) Allocation to fund for indirect medical education. ~~Except as reduced pursuant to subparagraph 79.1(5)*"y"*(6), the~~ The total state fiscal year annual amount of funding that is allocated to the graduate medical education and disproportionate share fund for indirect medical education related to inpatient services ~~for July 1, 2008, through June 30, 2009,~~ is ~~$15,174,101~~ $14,415,396. If a hospital fails to qualify for indirect medical education payments from the fund because the hospital does not report direct medical education costs that qualify for payment as medical education costs under the Medicare program in the most recent cost report submitted before the start of the state fiscal year for which payments are

being made, the amount of money that would have been paid to that hospital shall be removed from the fund.

(6) Distribution to qualifying hospitals for indirect medical education. Distribution of the amount in the fund for indirect medical education shall be on a monthly basis. To determine the amount to be distributed to each qualifying hospital for indirect medical education, the following formula is used:

1. Multiply the total of all DRG weights for claims paid from ~~July 1, 2005, through June 30, 2006,~~ the GME/DSH fund apportionment claim set for each hospital reporting direct medical education costs that qualify for payment as medical education costs under the Medicare program in the hospital's base year cost report by each hospital's indirect medical education rate to obtain a dollar value.

2. Sum the dollar values for each hospital, then divide each hospital's dollar value by the total dollar value, resulting in a percentage.

3. Multiply each hospital's percentage by the amount allocated for indirect medical education to determine the payment to each hospital.

~~Effective for payments from the fund for July 2006, the state fiscal year used as the source of DRG weights shall be updated to July 1, 2005, through June 30, 2006. Thereafter, the state fiscal year used as the source of DRG weights shall be updated by a three-year period effective for payments from the fund for July of every third year.~~

~~If a hospital fails to qualify for indirect medical education payments from the fund because it does not report direct medical education costs that qualify for payment as medical education costs under the Medicare program in the most recent cost report submitted before the start of the state fiscal year for which payments are being made, the amount of money that would have been paid to that hospital shall be removed from the fund.~~

(7) Qualifying for disproportionate share. For months beginning with July 2002, hospitals qualify for disproportionate share payments from the fund when the hospital's low-income utilization rate exceeds 25 percent, when the hospital's Medicaid inpatient utilization rate exceeds one standard deviation from the statewide average Medicaid utilization rate, or when the hospital qualifies as a children's hospital under subparagraph (10). Information contained in the hospital's base year cost report is used to determine the hospital's low-income utilization rate and the hospital's Medicaid inpatient utilization rate.

For those hospitals that qualify for disproportionate share under both the low-income utilization rate definition and the Medicaid inpatient utilization rate definition, the disproportionate share percentage shall be the greater of (1) the product of 2½ percent multiplied by the number of standard deviations by which the hospital's own Medicaid inpatient utilization rate exceeds the statewide mean Medicaid inpatient utilization rate for all hospitals, or (2) 2½ percent.

For those hospitals that qualify for disproportionate share under the low-income utilization rate definition, but do not qualify under the Medicaid inpatient utilization rate definition, the disproportionate share percentage shall be 2½ percent.

For those hospitals that qualify for disproportionate share under the Medicaid inpatient utilization rate definition, but do not qualify under the low-income utilization rate definition, the disproportionate share percentage shall be the product of 2½ percent multiplied by the number of standard deviations by which the hospital's own Medicaid inpatient utilization rate exceeds the statewide mean Medicaid inpatient utilization rate for all hospitals.

For those hospitals that qualify for disproportionate share as a children's hospital, the disproportionate share percentage shall be the greater of (1) the product of 2½ percent multiplied by the number of standard deviations by which the Medicaid inpatient utilization rate for children under 18 years of age at the time of admission in all areas of the hospital where services are provided predominantly to children under 18 years of age exceeds the statewide mean Medicaid inpatient utilization rate for all hospitals, or (2) 2½ percent.

~~Information contained in the hospital's available 2004 submitted Medicare cost report is used to determine the hospital's low-income utilization rate and the hospital's Medicaid inpatient utilization rate.~~

Additionally, a qualifying hospital other than a children's hospital must also have at least two obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric services

to Medicaid-eligible persons who are in need of obstetric services. In the case of a hospital located in a rural area as defined in Section 1886 of the Social Security Act, the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.

Out-of-state hospitals serving Iowa Medicaid patients qualify for disproportionate share payments from the fund based on their state Medicaid agency's calculation of the Medicaid inpatient utilization rate. The disproportionate share percentage is calculated using the number of standard deviations by which the hospital's own state Medicaid inpatient utilization rate exceeds the hospital's own statewide mean Medicaid inpatient utilization rate.

Hospitals qualify for disproportionate share payments from the fund without regard to the facility's status as a teaching facility or bed size.

Hospitals receiving reimbursement as critical access hospitals shall not qualify for disproportionate share payments from the fund.

(8) Allocation to fund for disproportionate share. The total state fiscal year annual amount of funding that is allocated to the graduate medical education and disproportionate share fund for disproportionate share payments ~~for July 1, 2008, through June 30, 2009,~~ is ~~$7,253,641~~ $6,890,959. If a hospital fails to qualify for disproportionate share payments from the fund due to closure or for any other reason, the amount of money that would have been paid to that hospital shall be removed from the fund.

(9) Distribution to qualifying hospitals for disproportionate share. Distribution of the amount in the fund for disproportionate share shall be on a monthly basis. To determine the amount to be distributed to each qualifying hospital for disproportionate share, the following formula is used:

1. Multiply the total of all DRG weights for claims paid ~~July 1, 2005, through June 30, 2006,~~ from the GME/DSH fund apportionment claim set for each hospital that met the qualifications during the fiscal year used to determine the hospital's low-income utilization rate and Medicaid utilization rate (or for children's hospitals, during the preceding state fiscal year) by each hospital's disproportionate share rate to obtain a dollar value. For any hospital that qualifies for a disproportionate share payment only as a children's hospital, only the DRG weights for claims paid for services rendered to patients under 18 years of age at the time of admission in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age shall be used in this calculation.

2. Sum the dollar values for each hospital, then divide each hospital's dollar value by the total dollar value, resulting in a percentage.

3. Multiply each hospital's percentage by the amount allocated for disproportionate share to determine the payment to each hospital.

~~Effective for payments from the fund for July 2006, the state fiscal year used as the source of DRG weights shall be updated to July 1, 2005, through June 30, 2006. Thereafter, the state fiscal year used as the source of DRG weights shall be updated by a three-year period effective for payments from the fund for July of every third year.~~ In compliance with Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 (Public Law 102-234) and 1992 Iowa Acts, chapter 1246, section 13, the total of disproportionate share payments from the GME/DSH fund and supplemental disproportionate share of payments pursuant to paragraph ~~79.1(5)*"ab,"*~~ 79.1(5)*"u"* or 79.1(5)*"v"* cannot exceed the amount of the federal cap under Public Law 102-234. ~~If a hospital fails to qualify for disproportionate share payments from the fund due to closure or for any other reason, the amount of money that would have been paid to that hospital shall be removed from the fund.~~

ITEM 11. Rescind paragraphs **79.1(5)"ab"** and **"ac."**

ITEM 12. Amend paragraph **79.1(8)"g"** as follows:

g. ~~The~~ For services rendered on or after July 1, 2010, the professional dispensing fee is ~~$4.57~~ $4.34 or the pharmacy's usual and customary fee, whichever is lower~~, except for the period from December 1, 2009, to June 30, 2010, during which the professional dispensing fee shall be $4.34~~.

ITEM 13. Amend subparagraphs **79.1(15)"f"(2)** and **(3)** as follows:

(2) Revenues exceeding 100 percent of adjusted actual costs ~~by more than 2.5 percent~~ shall be remitted to the department. Payment will be due upon notice of the new rates and retrospective adjustment.

(3) Providers who do not reimburse revenues exceeding ~~2.5~~ 100 percent of actual costs 30 days after notice is given by the department will have the revenues over ~~2.5~~ 100 percent of the actual costs deducted from future payments.

ITEM 14. Amend paragraph **79.1(16)"a,"** definitions of "Base year cost report," and "Graduate medical education and disproportionate share fund," as follows:

"Base year cost report," for rates effective ~~July 1, 2008~~ January 1, 2009, shall mean the hospital's cost report with fiscal year end on or after January 1, ~~2006~~ 2007, and before January 1, ~~2007~~ 2008. Cost reports shall be reviewed using Medicare's cost reporting and cost reimbursement principles for those cost reporting periods.

"Graduate medical education and disproportionate share fund" or *"GME/DSH fund"* shall mean a reimbursement fund developed as an adjunct reimbursement methodology to directly reimburse qualifying hospitals for the direct costs of interns and residents associated with the operation of graduate medical education programs for outpatient services.

ITEM 15. Adopt the following **new** definitions of "GME/DSH fund apportionment claim set," "GME/DSH fund implementation year" and "Medicaid claim set" in paragraph **79.1(16)"a"**:

"GME/DSH fund apportionment claim set" means the hospital's applicable Medicaid claims paid from July 1, 2008, through June 30, 2009. The claim set is updated every three years in July.

"GME/DSH fund implementation year" means 2009.

"Medicaid claim set" means the hospital's applicable Medicaid claims for the period of January 1, 2006, through December 31, 2007, and paid through March 31, 2008.

ITEM 16. Amend subparagraphs **79.1(16)"c"(2)** and **(4)** as follows:

(2) Except as provided in paragraph 79.1(16)*"h,"* outpatient hospital services that have been assigned to an APC with an assigned weight shall be reimbursed based on the APC to which the services provided are assigned. ~~For dates of services beginning on or after July 1, 2008, the~~ The department adopts and incorporates by reference the OPPS APCs and relative weights effective January 1, 2008, published on November 27, 2007, as final by the Centers for Medicare and Medicaid Services in the Federal Register at Volume 72, No. 227, page 66579. Relative weights and APCs shall be updated pursuant to paragraph 79.1(16)*"j."*

(4) The OPPS APC payment status indicators show whether a service represented by a CPT or HCPCS code is payable under an OPPS APC or under another payment system and whether particular OPPS policies apply to the code. The following table lists the status indicators and definitions for both services that are paid under an OPPS APC and services that are not paid under an OPPS APC.

Indicator	Item, Code, or Service	OPPS Payment Status
A	Services furnished to a hospital outpatient that are paid by Medicare under a fee schedule or payment system other than OPPS, such as: ● Ambulance services. ● Clinical diagnostic laboratory services. ● Diagnostic mammography. ● Screening mammography. ● Nonimplantable prosthetic and orthotic devices. ● Physical, occupational, and speech therapy. ● Erythropoietin for end-stage renal dialysis (ESRD) patients. ● Routine dialysis services provided for ESRD patients in a certified dialysis unit of a hospital.	~~If~~ For services covered by Iowa Medicaid as an outpatient hospital service, the service is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)*"c."* ~~If~~ For services not covered by Iowa Medicaid as an outpatient hospital service, the service is not paid under OPPS APC, but may be paid by Iowa Medicaid under the specific rate or methodology established by other rules (other than outpatient hospital).

Indicator	Item, Code, or Service	OPPS Payment Status
B	Codes that are not paid by Medicare on an outpatient hospital basis	Not paid under OPPS APC. ● May be paid when submitted on a different bill type other than outpatient hospital (13x). ● An alternate code that is payable when submitted on an outpatient hospital bill type (13x) may be available.
C	Inpatient procedures	If covered by Iowa Medicaid as an outpatient hospital service, the service is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)*"c."* If not covered by Iowa Medicaid as an outpatient hospital service, the service is not paid under OPPS APC. Admit the patient and bill as inpatient care.
D	Discontinued codes	Not paid under OPPS APC or any other Medicaid payment system.
E	Items, codes, and services: ● That are not covered by Medicare based on statutory exclusion and may or may not be covered by Iowa Medicaid; or ● That are not covered by Medicare for reasons other than statutory exclusion and may or may not be covered by Iowa Medicaid; or ● That are not recognized by Medicare but for which an alternate code for the same item or service may be available under Iowa Medicaid; or ● For which separate payment is not provided by Medicare but may be provided by Iowa Medicaid.	If covered by Iowa Medicaid, the item, code, or service is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)*"c."* If not covered by Iowa Medicaid, the item, code, or service is not paid under OPPS APC or any other Medicaid payment system.
F	Certified registered nurse anesthetist services Corneal tissue acquisition Hepatitis B vaccines	If covered by Iowa Medicaid, the item or service is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)*"c."* If not covered by Iowa Medicaid, the item or service is not paid under OPPS APC or any other Medicaid payment system.
G	Pass-through drugs and biologicals	If covered by Iowa Medicaid, the item is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)*"c."* If not covered by Iowa Medicaid, the item is not paid under OPPS APC or any other Medicaid payment system.

Indicator	Item, Code, or Service	OPPS Payment Status
H	Pass-through device categories	If covered by Iowa Medicaid, the device is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)*"c."* If not covered by Iowa Medicaid, the device is not paid under OPPS APC or any other Medicaid payment system.
K	~~Blood and blood products~~ ~~Brachytherapy sources~~ Non-pass-through drugs and biologicals Therapeutic radiopharmaceuticals	If covered by Iowa Medicaid, the item is: ● Paid under OPPS APC with a separate APC payment when both an APC and an APC weight are established. ● Paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)*"c"* when either no APC or APC weight is established. If not covered by Iowa Medicaid, the item is not paid under OPPS APC or any other Medicaid payment system.
L	Influenza vaccine Pneumococcal pneumonia vaccine	If covered by Iowa Medicaid, the vaccine is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)*"c."* If not covered by Iowa Medicaid, the vaccine is not paid under OPPS APC or any other Medicaid payment system.
M	Items and services not billable to the Medicare fiscal intermediary	If covered by Iowa Medicaid, the item or service is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)*"c."* If not covered by Iowa Medicaid, the item or service is not paid under OPPS APC or any other Medicaid payment system.
N	Packaged services not subject to separate payment under Medicare OPPS payment criteria	Paid under OPPS APC. Payment, including outliers, is included with payment for other services; therefore, no separate payment is made.
P	Partial hospitalization	Not a covered service under Iowa Medicaid.
~~Q~~	~~Packaged services subject to separate payment under Medicare OPPS payment criteria~~	~~Paid under OPPS APC in a separate APC payment based on Medicare OPPS payment criteria.~~ ~~If criteria are not met, payment, including outliers, is packaged into payment for other services; therefore, no separate APC payment is made.~~

Indicator	Item, Code, or Service	OPPS Payment Status
Q1	STVX-packaged codes	Paid under OPPS APC. ● Packaged APC payment if billed on the same date of service as HCPCS code assigned status indicator "S," "T," "V," or "X." ● In all other circumstances, payment is made through a separate APC payment.
Q2	T-packaged codes	Paid under OPPS APC. ● Packaged APC payment if billed on the same date of service as HCPCS code assigned status indicator "T." ● In all other circumstances, payment is made through a separate APC payment.
Q3	Codes that may be paid through a composite APC	If covered by Iowa Medicaid, the code is paid under OPPS APC with separate APC payment. If not covered by Iowa Medicaid, the code is not paid under OPPS APC or any other Medicaid payment system.
R	Blood and blood products	If covered by Iowa Medicaid, the item is paid under OPPS APC with separate APC payment. If not covered by Iowa Medicaid, the item is not paid under OPPS APC or any other Medicaid payment system.
S	Significant procedure, not discounted when multiple	If covered by Iowa Medicaid, the procedure is paid under OPPS APC with separate APC payment. If not covered by Iowa Medicaid, the procedure is not paid under OPPS APC or any other Medicaid payment system.
T	Significant procedure, multiple reduction applies	If covered by Iowa Medicaid, the procedure is paid under OPPS APC with separate APC payment subject to multiple reduction. If not covered by Iowa Medicaid, the procedure is not paid under OPPS APC or any other Medicaid payment system.

Indicator	Item, Code, or Service	OPPS Payment Status
U	Brachytherapy sources	If covered by Iowa Medicaid, the procedure is paid under OPPS APC with separate APC payment. If not covered by Iowa Medicaid, the procedure is not paid under OPPS APC or any other Medicaid payment system.
V	Clinic or emergency department visit	If covered by Iowa Medicaid, the service is paid under OPPS APC with separate APC payment. If not covered by Iowa Medicaid, the service is not paid under OPPS APC or any other Medicaid payment system.
X	Ancillary services	If covered by Iowa Medicaid, the service is paid under OPPS APC with separate APC payment. If not covered by Iowa Medicaid, the service is not paid under OPPS APC or any other Medicaid payment system.
Y	Nonimplantable durable medical equipment	For items covered by Iowa Medicaid as an outpatient hospital service, the item is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospitals services established pursuant to 79.1(1)*"c."* For items not covered by Iowa Medicaid as an outpatient hospital service, the item is not paid as an outpatient hospital service, but may be paid by Iowa Medicaid under the specific rate or methodology established by other rules (other than outpatient hospital).

ITEM 17. Amend paragraph **79.1(16)"d,"** introductory paragraph, as follows:

d. Calculation of case-mix indices. Hospital-specific and statewide case-mix indices shall be calculated using ~~all applicable claims with dates of service occurring in the period July 1, 2006, through June 30, 2007, paid through September 10, 2007~~ the Medicaid claim set.

ITEM 18. Amend subparagraphs **79.1(16)"e"(2)** and **(4)** as follows:

(2) The cost-to-charge ratios are applied to each line item charge reported on claims ~~with dates of service occurring in the period July 1, 2006, through June 30, 2007, paid through September 10, 2007,~~ from the Medicaid claim set to calculate the Medicaid cost per service. The hospital's total outpatient Medicaid cost is the sum of the Medicaid cost per service for all line items.

(4) The remaining amount is multiplied by a factor to limit aggregate expenditures to available funding, divided by the hospital-specific case-mix index, and then divided by the total number of APC services for that hospital ~~during the period July 1, 2006, through June 30, 2007, that were paid through September 10, 2007~~ from the Medicaid claim set.

ITEM 19. Amend subparagraph **79.1(16)"f"(2)** as follows:

(2) The resulting amount is multiplied by a factor to limit aggregate expenditures to available funding, divided by the statewide case-mix index, and then divided by the statewide total number of APC services ~~for the period July 1, 2006, through June 30, 2007, that were paid through September 10, 2007~~ from the Medicaid claim set.

ITEM 20. Rescind and reserve paragraph **79.1(16)"t."**

ITEM 21. Amend subparagraphs **79.1(16)"v"(2)** and **(3)** as follows:

(2) Allocation to fund for direct medical education. ~~Except as reduced pursuant to subparagraph 79.1(16)*"v"*(3), the~~ The total ~~amount of~~ annual state fiscal year funding that is allocated to the graduate

medical education and disproportionate share fund for direct medical education related to outpatient services ~~for July 1, 2008, through June 30, 2009,~~ is ~~$2,922,460~~ $2,776,336. If a hospital fails to qualify for direct medical education payments from the fund because the hospital does not report direct medical education costs that qualify for payment as medical education costs under the Medicare program in the most recent cost report submitted before the start of the state fiscal year for which payments are being made, the amount of money that would have been paid to that hospital shall be removed from the fund.

(3) Distribution to qualifying hospitals for direct medical education. Distribution of the amount in the fund for direct medical education shall be on a monthly basis. To determine the amount to be distributed to each qualifying hospital for direct medical education, the following formula is used:

1. Multiply the total count of outpatient visits for claims paid from ~~July 1, 2005, through June 30, 2006,~~ the GME/DSH fund apportionment claim set for each hospital reporting direct medical education costs that qualify for payment as medical education costs under the Medicare program in the hospital's base year cost report by each hospital's direct medical education rate to obtain a dollar value.

2. Sum the dollar values for each hospital, then divide each hospital's dollar value by the total dollar value, resulting in a percentage.

3. Multiply each hospital's percentage by the amount allocated for direct medical education to determine the payment to each hospital.

~~Effective for payments from the fund for July 2006, the state fiscal year used as the source of the count of outpatient visits shall be updated to July 1, 2005, through June 30, 2006. Thereafter, the state fiscal year used as the source of the count of outpatient visits shall be updated by a three-year period effective for payments from the fund for July of every third year.~~

~~If a hospital fails to qualify for direct medical education payments from the fund because it does not report direct medical education costs that qualify for payment as medical education costs under the Medicare program in the most recent cost report submitted before the start of the state fiscal year for which payments are being made, the amount of money that would have been paid to that hospital shall be removed from the fund.~~

ITEM 22. Amend subparagraph **79.1(23)"c"(1)** as follows:

(1) A reasonable cost for a member is one that does not exceed 110 percent of the average allowable costs reported by Iowa Medicaid providers for providing similar remedial services to members who have similar diagnoses and live in similar settings, less 5 percent.

ITEM 23. Rescind and reserve rule **441—79.16(249A)**.

ITEM 24. Amend subrule 85.25(1) as follows:

85.25(1) *Computation of inpatient rate.* Facilities are paid at a per diem rate based on the facility's actual and allowable cost for the service not to exceed the upper limit as provided in 441—subrule 79.1(2).

a. and *b.* No change.

c. For services rendered July 1, ~~2009~~ 2010, through June 30, ~~2010~~ 2011, rates paid shall be adjusted to 100 percent of the facility's actual and allowable average costs per patient day, based on the cost information submitted pursuant to paragraphs 85.25(1)*"a"* and *"b,"* subject to the upper limit provided in 441—subrule 79.1(2) for non-state-owned facilities. ~~Facilities may submit a projected cost report for purposes of determining the rates initially paid for services rendered July 1, 2009, through June 30, 2010, before rate adjustment based on actual costs.~~ Before rate adjustment, providers shall be paid a prospective interim rate equal to the previous year's retrospectively calculated unit-of-service rate.

[Filed Emergency 6/10/10, effective 7/1/10]
[Published 6/30/10]

EDITOR'S NOTE: For replacement pages for IAC, see IAC Supplement 6/30/10.